National Health Policy 2010

Full first draft, 19 September 2009

for sharing with health sector stakeholders at AJHSR and subsequent approval by MoHSW leadership, before onward submission to PS Committee, Cabinet and House of Representatives

Ministry of Health and Social Welfare
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Foreword

(by the Minister of Health and Social Welfare)
Preamble

The purpose of the national health policy is to provide general directions to health sector development, in line with Government’s role – which it has delegated to the Ministry of Health and Social Welfare – to regulate the health sector.

We would like to point out that the MoHSW is not the sole implementer of the national health policy, nor is it the sole provider of health services in Zanzibar. But we do hope that the ambitions reflected in this document receive the full support from other government departments and non-governmental organizations, including development partners.

Determinants of health are multiple, and lie for a large part outside the sphere of command of the health sector per se. The state of the national economy and employment opportunities, educational standards and school enrolment, sanitation and environmental hygiene, gender equity, social protection and universal health care all have an influence on people’s health. And vice versa: healthy citizens are more likely to make a positive contribution to the nation’s social and economic development.

This is why the World Health Organisation set up the Commission on Social Determinants of Health. In its final report in 2008, the Commission stated that:

“Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted. Increasingly the nature of the health problems rich and poor countries have to solve are converging. The development of a society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.”

The Commission therefore called on the WHO and ...

“... all governments to lead global action on the social determinants of health with the aim of achieving health equity. It is essential that governments, civil society, WHO, and other global organizations now come together in taking action to improve the lives of the world’s citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.”

The national health policy of Zanzibar takes into account the social determinants of health. For its implementation, under the leadership of the MoHSW, it requires the full support from all government departments, as well as from non-governmental agencies and international development partners.

The development of the new national health policy for Zanzibar was based on broad consultations with various stakeholders, such as political parties, ward councillors, the
House of Representatives committee for Social Welfare and Women’s Development. Representatives from Government institutions, the private sector, CBO/NGOs and development partners also raised a number of critical issues facing the health sector, which have helped shape the new policy.

The new health policy replaces the previous version (dated 1999) and takes precedence over all sub-sector policies, as they exist for instance for medicines and certain disease control programmes. (New sub-sector policies will be aligned with and make due reference to the new health policy.)

Once adopted by the House of Representatives, the MoHSW will take the lead in elaborating a five-year health sector strategic plan that will set objectives for implementation, elaborate sub-sector strategies and set targets over a five year period; and it will provide indicative budget estimates.

Two health sector strategic plans are foreseen, covering the period 2011-2015 and 2016-2020. The 2011-2015 health sector strategy (which will replace the 2006/07 – 2010/11 ZHSRSP), will be aligned, and its cycle harmonized, with Vision 2020, the new MKUZA and other sector policies (for education, agriculture, etc).

A Swahili version of the national health policy will be made available before ....
Abbreviations

AJHSR  Annual joint health sector review
CBO   Community-based organisation
CDHP  Comprehensive district health plan
CHS   College of Health Sciences
CMS   Central Medical Stores
CSO   Civil society organisation
CSPD  Child Survival, Protection and Development programme
DHMT  District Health Management Team
DP    Development partners
EHCP  Essential health care package
EML   Essential medicines list
EPI   Expanded Programme for Immunisation
GO    Government order
GoZ   Government of Zanzibar
HCEU  Health Care Engineering Unit
HIS   Health information system
HMIS  Health management information system
HRD   Human resource development
HRH   Human resources for health
HRIS  Human resource information system
HRM   Human resource management
HSF   Health Service Fund
HSPS  Health Sector Programme Support (Danida funded)
HSRS  Health Sector Reforms Secretariat (MoHSW)
ICT   Information and communication technology
IEC   Information, Education and Communication
IPC   Infection prevention and control
MDA   Ministries, departments and agencies
MDG   Millennium development goals
MKUZA Kiswahili acronym for ZSGRP
MMH   Mnazi Mmoja Hospital
MoFEA  Ministry of Finance and Economic Affairs
MoHSW  Ministry of Health and Social Welfare
MSD   Medical Stores Department (Tanzania mainland)
MTEF  Medium Term Expenditure Framework
MVC   Most vulnerable children
NACTE  National Council for Technical Education (Tanzania)
NGO   Non-governmental organisation
NHA   National Health Accounts
OVC   Orphans and vulnerable children
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>PCM</td>
<td>Partners coordination meeting</td>
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<tr>
<td>PE</td>
<td>Personal emoluments (GOZ budget line)</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>PHCU</td>
<td>Primary health care unit</td>
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<td>PHL</td>
<td>Public Health Laboratory (Pemba)</td>
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<td>POA</td>
<td>(annual) Plan of Action</td>
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<td>PPP</td>
<td>Public-private partnership</td>
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<td>PS</td>
<td>Principal Secretary</td>
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<td>QIRI</td>
<td>Quality Improvement and Recognition Initiative</td>
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<td>RALG</td>
<td>Regional Administration and Local Government</td>
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<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
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<tr>
<td>SHCC</td>
<td>Shehia Health Custodian Committee</td>
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<td>STD</td>
<td>Sexually transmitted disease</td>
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<td>STG</td>
<td>Standard treatment guidelines</td>
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<td>SWAp</td>
<td>Sector-wide approach</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TWG</td>
<td>Technical working group</td>
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<td>UN</td>
<td>United Nations</td>
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<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>ZANA</td>
<td>Zanzibar Nurses Association</td>
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<td>ZFDB</td>
<td>Zanzibar Food and Drugs Board</td>
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<td>ZHSRSP</td>
<td>Zanzibar Health Sector Reform Strategic Plan</td>
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<td>ZMCP</td>
<td>Zanzibar Malaria Control Programme</td>
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<td>ZOP</td>
<td>Zanzibar Outreach Programme</td>
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<td>ZSGRP</td>
<td>Zanzibar Strategy for Growth and the Reduction of Poverty</td>
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<td>ZSSF</td>
<td>Zanzibar Social Security Fund</td>
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1. Introduction

The present National Health Policy is based on:
- Zanzibar Vision 2020 and
- MKUZA, the Zanzibar Strategy for Growth and the Reduction of Poverty.

Other documents that have inspired the policy are:
- The draft Public Service Policy, in particular its emphasis on building an efficient, transparent, equitable and productive public service (vision); and on a proactive and responsive public service to the people’s demand (mission).
- Population Policy 2008, in particular the priority issues of reproductive health and STD/HIV/AIDS.

The policy ties in with international declarations and resolutions to which the United Republic of Tanzania has committed itself:
- The Cairo Declaration on Population and Development of 1994
- The UN Millennium Declaration of September 2000 and the MDG’s
- The Abuja Declaration adopted at the April 2001 summit of African leaders

The new national health policy differs from its predecessor (1999 Health Policy) in that the 11 ‘reform areas’ have been rearranged into 11 policy areas. Certain policy choices have been articulated more clearly.

Scarcity of resources, equity and scientific evidence about the effectiveness of health interventions are the three main considerations that have informed the choices presented in the national health policy. The major choices are as follows:

1. Priority to health service delivery, while limiting the size of administrative organs, such as the Ministerial Head Quarters and zonal and district offices. The present workforce at these administrative organs is considered too large for the size of the country and its national budget. The workforce will therefore be downscaled, where appropriate, for efficiency sake.

2. Priority to quality services at the primary health care level, rather than expansion of tertiary care.

3. Priority to self-reliance for health personnel, rather than continuing the dependence on expatriate medical specialists and other health cadres.

4. When considering new investments (investments in health infrastructure, new medical procedures, new technologies, new types of expertise, new intervention strategies), the recurrent cost implications will be a major factor to decide whether or not to actually engage in the investments concerned. If the recurrent costs are not adequately covered, the Ministry may decline the proposed investment.
5. Decisions will be guided by a careful weighing of the ‘trade-off’ between quantity and quality. This means, for instance, that certain health services will be concentrated in a few health institutions only (or in a single institution), rather than spread them over the entire country. In cases where Zanzibar itself cannot afford the provision of a particular service or medical procedure, the services may be obtained from elsewhere (outside the country).

6. Maximise the efficient use of resources that are already available, before trying to generate additional resources (whether domestic or external).

The structure of the policy is as follows:
- Vision, mission statement, values (chapter 2)
- 11 Policy areas (chapter 3)
- 6 Implementation arrangements (chapter 4).

For each of the 11 policy areas and six implementation arrangements, this document will present: the issues at hand, as well as the gaps, challenges and opportunities as they are perceived. Based on these, for each policy area one or more policy ambitions are articulated in the form of statement, followed by a set of strategies that will be employed to realise the ambitions.
2. Vision, mission statement and values

Vision of the Government of Zanzibar:

*A healthy population, with reliable, accessible and equitable health care services.*

Taking into account that the Government is not the sole provider of health services, it is emphasised that the Ministry of Health & Social Welfare has primarily a regulatory role. Its main role is to oversee and regulate the provision of health services to the population, irrespective of the type of provider.

Hence, the mission of the MoHSW is as follows.

Mission of the MoHSW:

*To ensure that all Zanzibari’s secure their right to quality health services, rendered in a cost-effective and affordable manner.*

In order to realise this mission, a number of core values are considered important.

Respect of human rights is the overriding value of the Government’s health policy. This includes:

- People’s right to the best possible health services
- Their right to health-related information and
- Their right to be heard and to be included in decision making on health matters.

Equity and quality are two other core values.

Equity implies:

- Equitable distribution of resources
- Equitable access to services, in geographical, financial and socio-cultural terms
- Protection of vulnerable groups and people with disadvantages
- Special attention to gender inequities.

Quality is pursued in all its dimensions:

- Responsiveness to people’s health needs and their demands for quality services
- Adherence to national standards and standard treatment guidelines
- Transparency in decision making
- Accountability for decisions made and for past performance.
3. Policy areas

3.1 Health sector governance

Issues
• Leadership and sector coordination
• Mandates, roles and responsibilities of MoHSW departments and units
• Structure of the MoHSW, organogram
• Dialogue and transparency in decision making
• Accountability
• Public participation in health matters and decision making.

Note 1: The legal aspects of governance are covered in section 3.7, Health legislation and regulation.

Note 2: Human rights are covered in section 3.11, Cross-cutting themes.

Note 3: Public participation in health matters is also covered in section 4.1, Community health promotion.

Gaps
• The Ministry of Health and Social Welfare is considered top heavy
• Roles and responsibilities of MoHSW departments and units are not always clear
• Lines of accountability are not clear for some MoHSW departments and units
• Professional boards and councils are not all active, do not all have clear mandates and do not effectively monitor codes of conduct and professional ethics
• General Orders (GO) which govern civil services are not always well understood and followed.

Challenges
• Provide clarity at all levels about Government’s ambition for health sector development
• Oversee and improve the functionality of MoHSW departments; clarify lines of accountability
• Mnazi Mmoja Hospital, Central Medical Stores and the College of Health Sciences are yet to fully function as semi-autonomous institutions
• Increase dialogue within the health sector
• Increase transparency of decisions and of the decision making process
• Strengthen the local ownership of externally supported programmes.

Opportunities
• MoHSW leaders underwent leadership and management training
• Existence of the Health Sector Reforms Secretariat
• Existence of health laws that govern councils and boards
• Recognition of the College of Health Sciences by NACTE.
Policy statements

- Fulfilment of the regulatory role of the MoHSW
- Transparency in decision making, especially when it involves shifts in resource allocation
- Accountability for performance: both within the MoHSW and the health sector as a whole, as well as upwards (to higher levels of Government, parliament) and downwards (to the general public)
- Participation of the public in health matters and decision making.

Strategies

- Review the structure of the MoHSW, clarify the lines of accountability, formally adopt the new organogram and ensure compliance
- Strengthen boards and councils in their respective regulatory roles
- Support professional associations in their role to advance professionalism and adherence to quality standards
- Utilise General Orders (GO’s) within the MoHSW, where appropriate, and enforce their adherence
- Provide periodic accounts to parliament and the general public of health sector achievements and decisions made
- Establish mechanisms for clients to lay their claims
- Establish mechanisms to monitor and report on client satisfaction
- Establish mechanisms for the public to participate in decision making.
3.2 Health service delivery

Issues
- Equitable access and service quality
- Preventive, curative and rehabilitative services
- Services for both communicable and non-communicable conditions
- Patient/client referral and continuum of care
- Health emergencies and medical evacuations
- Referrals and evacuations abroad.

Note: Health promotion is perceived as an implementation arrangement and will be dealt with in section 4.1.

Gaps
- Equitable access not ensured because of financial, socio-cultural and/or geographical barriers; or because of limited clinic opening hours
- Quality services not ensured because of shortages in qualified staff, appropriate equipment, drugs and/or medical supplies; or because of non-adherence to standard protocols and guidelines, or unprofessional health staff behaviour in general
- Inadequate service quality at PHCU level leading to self-referrals
- No clear guidelines and facilities in place for patient referral and counter-referral
- No established referral procedures between the public sector and private providers of health services (private hospitals/clinics or traditional healers).

Challenges
- Ensure access to health services for those who are not able to pay user fees
- Promote access of residents from Pemba and small islands to tertiary health services (available from Mnazi Mmoja Hospital)
- Reduce clinic congestion and undue use of tertiary facilities
- Increase health service quality across the board at all levels of the health care system
- Ensure that clients see the 'right' health worker without any unnecessary delay
- Ensure access for the general public to health information that will promote healthy life styles
- Intensify prevention of both communicable conditions (infections) and non-communicable conditions (hypertension, diabetes, road accidents, substance abuse and others)
- Improve treatment and rehabilitation of psychological disorders and other debilitating conditions
- Address health emergencies.

Opportunities
- Good network of PHCUs, with the large majority of the population living within 5 km of a health facility
- Essential health care packages defined (EHCP)
- Availability of agreed standards and treatment protocols
Quality assessment tools available (QIRI)
Guidelines available for integrated national healthcare supervision
Maternal death audits introduced in all hospitals
Existence of professional boards that regulate standards
Renovated rehabilitation unit at Mnazi Mmoja Hospital
Ongoing outreach programmes to provide certain specialist services to selected places in Pemba and Unguja
Ongoing initiative to improve the uptake and quality of maternal health services ('wired mothers').

Policy statements

- Equal opportunity of access to essential health services in six priority areas:
  a. Reproductive and child health (RCH)
  b. Communicable disease control
  c. Non-communicable disease control
  d. Mental health
  e. Control of substance abuse
  f. Social welfare
- Quality of essential health services provided to clients in the above priority areas – in terms of prevention, early diagnosis, treatment, rehabilitation and palliative care – at all levels of the national health system
- Adequate patient referral
- Equal opportunities for efficient medical evacuations, where appropriate
- Equal opportunities for medical treatment abroad.

Strategies

- Control the spread of communicable and non-communicable diseases
- Give special attention to emerging diseases
- Strengthen health care services of rape and other criminal acts
- Pursue quality assurance, through QIRI and other methods
- Promote client friendly services at all level of care
- Develop guidelines for patient referral and counter referral, taking into account the capacity of private hospitals
- Develop an equitable mechanism for evacuating patients with acute conditions, including those unable to pay the cost involved
- Make the existing mechanism of subsidised medical treatment abroad more equitable and affordable
- Intensify health education and health promotion among the general public
- Ensure adequate rehabilitation of people with debilitating conditions (including rehabilitation of drug abusers outside the mental health hospital; and rehabilitation services for physically handicapped in Pemba).
3.3 Social welfare

Issues
- There are various disadvantaged and vulnerable groups in society, each with their own special needs: orphans (OVC), drug/substance abusers, victims of rape or other criminal offence, mentally handicapped, impoverished people (‘destitute’), elderly without reliable caretakers
- Access of these groups to basic social services (including health services)
- Access of these groups to social welfare support
- Protection of their rights to be heard and to lead a meaningful life.

Gaps
- Fragmentation of responsibilities: disadvantaged and vulnerable groups are targeted by different government departments
- Social welfare services are largely confined to urban areas; rural populations are deprived of such services
- Poor infrastructure and low quality of services provided at Nyumba ya Watoto Forodhani (an orphanage)
- Poor quality of services at old-age houses at Limbani, Sebleni and Welezo.

Challenges
- Ensure a stable institutional base of the Social Welfare Department (currently in the MoHSW) with a clear mandate
- Strengthen the skills of social workers
- Secure adequate government funding for social welfare activities
- Secure external funding (from the private sector, international NGOs, donors) for social welfare activities
- Integrate social welfare services within health care systems at all levels.

Opportunities
- Policy and statute available for the rights of children
- Commitment among some development partners and NGOs to address social welfare issues, especially with regard to OVC/MVC.

Policy statements
- Access of disadvantaged and vulnerable groups to quality health care and other social services
- Protection of their rights and assurance that their special needs are catered for.

Strategies
- Map out the profiles and special needs of various disadvantaged groups
- Conduct a comprehensive institutional analysis of social welfare activities and clarify the mandates, roles and responsibilities of Government agencies, including the Social Welfare Department
• Strengthen the capacity of the Social Welfare Department in exercising its regulatory role and create a conducive environment for social welfare activities
• Work with health institutions to ensure exemption from user fees for those who are unable to pay user fees (waiver scheme in cost sharing)
• Work with the Ministry of Education and other MDAs to safeguard access of disadvantaged children to school
• Improve the quality of care at the old-age houses in Pemba and Unguja
• Incorporate social welfare activities in comprehensive district health plans and in strategic plans and AOPs of the MoHSW
• Include budget lines for social welfare in MTEF and the annual MoHSW budget
• Work with other ministries to mainstream social welfare issues
• Raise funding for social welfare activities from sources outside the government
### 3.4 Human resources for health and social welfare

**Issues**
- Human resource development (HRD), through pre-service and in-service training
- Staff recruitment and deployment
- Human resource management (HRM) and staff retention
- Staff productivity.

**Gaps**

- **Gaps in human resource development (HRD)**
  - Lack of a training master plan
  - Financial constraints for both pre-service and in-service training
  - Lack of clarity about the criteria used to qualify for support for further studies

- **Gaps in staff recruitment and deployment**
  - No standardised system for recruitment within the civil service
  - No standardised system for staff deployment by the MoHSW
  - Inadequate capacity of the personnel unit in the MoHSW

- **Gaps in HRM and staff retention**
  - General lack of clarity about job descriptions
  - No staff performance appraisal system in place
  - Limited HRM skills among heads of institutions/departments
  - Dissatisfaction with the scheme of service and salary levels
  - Dissatisfaction with the working environment
  - Limited career perspectives for certain cadres
  - Lack of a workplace policy

**Challenges**

- **Challenges in human resource development**
  - Train adequate numbers of staff of all cadres through pre-service training
  - Produce multi-skilled cadres that are ready take up positions and responsibilities in the health sector

- **Challenges in staff recruitment and deployment**
  - Raise interest among staff for career development
  - Effectively deploy adequate numbers of staff to serve in less popular parts of the country

- **Challenges in HRM and staff retention**
  - Create a conducive working climate that is competitive with the private sector and employment conditions in other countries
  - Recognise and reward staff that demonstrate good performance
  - Increase staff productivity
  - Address the specific needs of health workers at the workplace in view of their increased vulnerability
Opportunities

- Availability of a technical working group on Human Resources for Health
- Training opportunities in Zanzibar and abroad
- Recently established partnership with a University in Cuba for the training of medical doctors
- Staff motivation to pursue further studies
- MoHSW commitment to support staff in developing their careers
- Support from development partners for local training programmes and other forms of capacity building
- E-learning programme in place for nurses
- Technical support to the MoHSW to strengthen HRM (through HSPS, phase IV).

Policy statements

- Self-reliance in human resources for health
- Standardised staff recruitment and deployment procedures
- Adequate human resource management at all levels
- Increased staff productivity
- Staff retention

Strategies

- Further strengthen the capacity of the College of Health Sciences and seek affiliation and cooperation with the State University of Zanzibar
- Develop and implement a human resource development master plan that focuses on self-reliance of medical and paramedical cadres
- Further pursue and expand e-learning
- Develop a human resource management information (HRIS) within the MoHSW and keep it up-to-date
- Review, implement and adhere to the standing order for deployment of health staff in the two islands
- Introduce a staff performance appraisal system
- Consider the establishment of a staff retention mechanism for all cadres in the health sector
- Review and improve staff entitlements in the scheme of service
- Consider the introduction of performance-based staff incentives (financial or otherwise)
- Provide amenities that reduce the vulnerability of health workers at the workplace.
3.5 **Infrastructure**

**Issues**
- Construction
- Rehabilitation
- Installation of new equipment
- Routine (preventive) maintenance
- Repairs
- Disposal and replacement of obsolete items

For:
- Physical infrastructure (buildings)
- Water and power supply (generators, solar panels)
- Medical equipment
- Communication facilities (telephones, internet)
- Transport facilities (vehicles)
- Electronic office equipment (computers, printers, photocopiers)
- Other essential equipment (refrigerators, incinerators)

**Gaps**
- Not all existing health facilities can be provided with adequate personnel
- Inadequate staff houses at some health facilities
- Inadequate office space and training facilities in some areas
- Structures sometimes not fit for people with physical disabilities
- No or unreliable electricity supply at some health facilities, especially in rural areas
- Essential equipment not always available
- No or unreliable communication and/or transport facilities in some areas

**Challenges**
- Adherence to the 2001 infrastructure masterplan that would guide infrastructure development and rehabilitation
- Limit the haphazard construction of new PHCUs and the undue upgrading of existing health facilities
- Adherence to standards for physical infrastructure and equipment
- Acquisition of title deeds for health facilities
- Reach consensus on the choice of facilities that will be upgraded to district hospitals in Unguja
- Implement plans to concentrate certain hospital services and medical expertise in Pemba, rather than spread them over different locations
- Address the lack of primary and secondary level health institutions in Unguja urban district so as to alleviate the undue patient load on Mnazi Mmoja Hospital
- Adequate reporting of breakdowns by health institutions to the Health Care Engineering Unit at the MoHSW
- Appropriate use of modern telecommunication technologies, such as mobile phones
- Reaching out to small islands and some remote areas in Unguja and Pemba in view of poor roads
- Adequate management, use and maintenance of the vehicle fleet and other transport facilities
• Reduction of donor dependence on infrastructure development, rehabilitation and maintenance.

Opportunities
• Availability of a dense network of physical health infrastructure (health centres and clinics)
• Recent upgrading of selected PHCUs to PHCU+, with a wider service package as defined in the EHCP
• Recent increase in the number and quality of staff houses
• Generators now available in all hospitals and solar power installations in some health facilities
• Availability of resource centres in health districts, with access to internet
• Regular visits of health institutions by staff from the Health Care Engineering Unit (HCEU) for preventive maintenance
• Improved capacity of the HCEU to repair buildings and breakdowns of equipment
• Maintenance contracts in place for certain medical equipment items
• Good cooperation with development partners.

Policy statements
- Construction and expansion of physical infrastructure according to agreed service packages; this implies that
  - New PHCUs will no longer be allowed
  - Undue upgrading of existing health facilities will also be disallowed
- Reinforcement of the existing mechanism for preventive maintenance and repair of health infrastructure
- Adequate medical equipment in the health facilities in line with the EHCP and agreed technical standards
- Adequate office equipment, power supply, communication and transport facilities.

Strategies
• Develop an infrastructure master plan and ensure strict adherence to it
• Acquire title deeds for health facilities
• Pursue the construction of staff houses, where appropriate
• Secure government funding for maintenance and repairs
• Strengthen public sector demand for services offered by the Health Care Engineering Unit
• Consider sub-contracting of maintenance and repairs to private enterprises, where appropriate
• Work closely together with other relevant ministries to improve roads and equip health facilities with reliable water and power supply
• Equip facilities with mobile phones, in particular those in remote areas
• Elaborate and implement a comprehensive ICT strategy to support general office management, HIS/HMIS, HRIS and e-learning, and to enable appropriate electronic networks.
3.6 Medical and non-medical supplies

Issues
Procurement and supply chain management, including:
- Selection and quantification of items
- Procurement
- Storage
- Distribution
- Rational use
- Disposal of expired items

For:
- Medicines
- Vaccines
- Other medical supplies (such as family planning commodities, syringes and needles, lab reagents, X-ray films, etc.)
- Non-medical supplies (such as stationery, linen, cleaning materials, laundry supplies, etc.)

Gaps
- Fragmentation of procurement across programmes with parallel procurement and supply systems, sometimes outside the Central Medical Stores (CMS)
- Very low government expenditure on drugs, causing donor dependence
- Limited technical capacity at the central level to develop and implement procurement plans
- Inadequate routine information about drug consumption levels to enable proper quantification of drug requirements
- Restrictions (limited flexibility) for CMS to procure outside MSD
- Outdated Essential Medicines List (EML, 2003; 2007 draft to be finalized and formally adopted)
- Non-adherence to the existing EML and Standard Treatment Guidelines (STG) by the drug procurement committee and prescribers
- Episodes of drug stock-outs and, at times, stock-piling of medicines
- Irrational use of medicines and other supplies
- Limited storage facilities at the zonal level
- Lack of guidelines for storage, distribution and dispensing
- Little information about effectiveness of traditional medicines

Challenges
- Adherence to essential medicines
- CMS has no budget allocation from the Government
- Leakage of material supplies from public health facilities to other outlets
- Monitoring and supervision of supply chain management in health institutions
- Assure a steady supply of non-medical

Opportunities
- Strong support from development partners
- Qualified staff at the central level
• Procurement committee in place
• Zanzibar Food and Drugs Board in place for controlling the safety and quality of medicines
• Some of the national programmes procure their supplies through CMS and pay storage and distribution charges
• Availability of essential facilities

Policy statements
- Sustained availability and accessibility of quality essential medicines and other medical and non-medical supplies
- Rational use of medicines and supplies.

Strategies
- Develop a consolidated procurement plan and advocate for its adherence by all programmes
- Formally recognise CMS as a semi-autonomous institution
- Advocate for multiple sources of supplies (including private wholesalers)
- Move from a ‘push system’ (based on drug kits) to an ‘indent system’ (based on health facilities’ own demands)
- Ensure smooth management of the procurement and supply chain for essential medicines and other supplies. This will be done by:
  - Finalising the revised EML
  - Adhering to EML and STG when ordering medicines
  - Monitoring drug consumption levels to allow proper quantification of requirements
  - Expanding storage space
  - Actively promoting adherence to STG and rational use of medicines
  - Strengthen ZFDB capacity for safety and quality of medicines
  - Developing guidelines and standard operating procedures for storage, distribution and dispensing
  - Establish an automated (computerised) system for inventory management of medical supplies at the CMS
3.7 Health legislation and regulation

Issues
- Review of the existing health laws and regulations
- Amendment and enactment
- Enforcement

Gaps
- Some of the ethical standards are not well known by the general public
- Insufficient adherence by some health workers to ethical standards, both in the public sector and in the private sector
- No public health laws in place (although some have been initiated by the MoHSW)

Challenges
- Raise public awareness of existing health laws and regulations
- Raise public awareness about patient rights and ethical standards
- Increase adherence to the rule of law and to ethical standards among health practitioners, in the public sector as well as in the private sector

Opportunities
- Existence of some health laws and regulations, which have already been enforced
- Expertise and instruments are available within the MoHSW to address legal issues

Policy statement
- Effective enforcement of updated laws and regulations in support of delivery of quality health services in an equitable manner.

Strategies
- Strengthen and support institutions (boards, councils and committees) responsible for enforcement
- Raise awareness of health laws and regulations among the public
- Actively ensure adherence to health laws and regulations
- Develop and promote a patients’ charter
- Develop and enforce an appropriate legal instrument for Shehia Health Custodian Committees (see Section 4.1, Community health promotion).
3.8 Information

Issues
- Collecting health and health-related information
- Sharing of relevant information through publication and meetings, where appropriate
- Storage of information for easy retrieval
- Use of available information.

Gaps and challenges
- No integrated health information system (HIS) in place, comprising various subsystems such as HMIS, disease surveillance, vital statistics, census data and survey results
- Data submitted through the HMIS are not always timely, accurate and complete
- Limited capacity for data management, analysis and interpretation
- Non-inclusion of private health facilities in the routine HMIS
- Lack of an ICT strategy and guidelines
- Limited technical capacity in epidemiology, biostatistics and ICT
- Not all relevant health information is captured by the HMIS unit

Opportunities
- Existence of the HMIS unit in the MoHSW
- Existence of a computerised district health information system, to which all districts, zones and the national level are connected through internet
- Functional HMIS website
- Presence of external support to establish a human resource information database (HRIS).

Policy statements
- Routine messages containing health information to raise awareness among the general public through appropriate media (radio, TV, printed materials)
- Improved Health Management Information System and effective use for informed decision making.

Strategies
- Develop and implement an IEC strategy targeted at the general public (see section 4.1, Community Health Promotion)
- Develop, solicit external support for and implement an ICT strategy for the health sector, to take advantage of the possibilities of modern technologies (such as e-learning, telemedicine)
- Reinforce the existing HMIS capacity
- Work towards integrated health information sub-systems
- Enhance intersectoral cooperation in all health information sub-systems.
3.9 **Innovation and research**

**Issues**
- Innovative approaches to health systems development and health service delivery
- Research for health systems development

**Gaps**
- Limited research capacity
- No unit or focal point in the MoHSW to oversee and coordinate research activities
- Medical research council not in place

**Challenges**
- Establish a national health research agenda, which indicates research priorities
- Facilitate the dissemination and use of research results
- Sustain the introduction of innovations, once they prove to be successful, beyond the duration of the respective projects

**Opportunities**
- Several innovations are ongoing (for instance e-learning) and information is being shared at various fora
- Availability of the IdC Public Health Laboratory in Pemba, with scope to improve its benefits for health systems development in Zanzibar
- Several studies have been conducted by various institutes and NGOs under national health programmes (ZMCP and others) or independently
- Medical Ethics Research Committee in place, although it does not yet have any legal authority or terms of reference.

**Policy statements**
- A conducive environment for research in health and health-related areas, in particular operational research from which the health sector may derive a benefit
- A conducive environment for innovations in the provision of health services and in health systems development.

**Strategies**
- Initiate promising innovations (such as e-learning and telemedicine), document and share their results.
- Establish a focal point for research within the MoHSW with a clear mandate and an appropriate legal framework
- Build and strengthen local health research capabilities
- Facilitate the appraisal of research results and their dissemination
- Document and share research results and promote their use (including the results of student research projects).
3.10 Health financing

Issues
- Health financing levels from various sources
- Budgets versus actual expenditure
- Financial management and cost containment
- Cost-sharing (user fees) as a source of revenue that is, for the time being, indispensable for health institutions to sustain their operations

Gaps
- Actual expenditure versus agreed priority areas for the health sector
- Guidelines for the implementation of cost-sharing and the proposed waiver scheme not yet approved by Cabinet, hence not used
- No health insurance scheme in place, let alone universal health insurance

Challenges
- Reduce the (presumed) high out-of-pocket expenditure of the general public to obtain health services (reliable data are not available)
- Increase the level of GoZ expenditure for health to international standards
- Ensure the timely disbursement of GoZ funds from the MoFEA to the MoHSW
- Ensure the timely distribution of released funds within the MoHSW
- Bring GoZ budget distribution within the MoHSW and actual expenditure more in line with the priorities in the agreed health sector strategy and with the approved annual plans of action
- Improve the predictability of funding levels
- Establish periodic National Health Accounts (NHA)

Opportunities
- Established routine of annual planning at the national and district levels, with plans of action (POA), annual budgets and a medium-term expenditure framework (MTEF)
- A set of financial rules and regulations is in place
- Good involvement of the House of Representatives in scrutinising the health budget before giving its approval
- Presence of the Zanzibar Social Security Fund (ZSSF)
- Presence of National Health Insurance Fund and other insurers
- Technical support from development partners in the area of health economics and financing
- Financial support from development partners (DPs) to the health sector.
Policy statements

- Commitment to the Abuja Declaration, stating that 15% of the government budget shall be allocated to health
- xx% of the Government health budget allocated to health districts, in support of primary health care
- Implementation of cost-sharing at public health facilities along with the waiver scheme as per the MoHSW guidelines
- Search for alternative ways of sustainable health financing, which shall replace cost-sharing in due course.

Strategies

- Rationalize the cost-sharing system and enforce waivers in order to protect the poor and disadvantaged
- Develop a comprehensive health care financing strategy
- Monitor and report on any discrepancies between actual health expenditure and agreed priorities for the health sector, as reflected in milestones and strategic plans
- Establish National Health Accounts and regularly conduct Public Expenditure Reviews (PER)
- Conduct or support studies that bring out opportunities to increase efficiency and effectiveness in the use of financial resources
- Work towards the establishment of social health insurance.
3.11 Cross-cutting themes

Issues
• Respect of human rights
• Gender equality
• Healthy environment within health facilities and other public institutions

Gaps
• Limited awareness among the public of their human rights and how people can claim their rights to quality services and the best possible standard of health
• Gender issues are often not recognised
• Limited awareness among health workers of the adverse effects of pharmaceutical products and medical waste on the environment
• Poor sanitary standards in public facilities.

Challenges
• Raise the commitment of the Medical Council, ZANA and other professional associations to promote respect of human rights and ethical codes of conduct among health workers
• Raise the awareness among health programme managers and health staff about gender inequalities in society that have health implications, as well as about the possible gender effects (positive or negative) of health services and programmes
• Raise the sanitary standards in public buildings and health facilities
• Ensure that women, girls and boys are protected against all forms of violence, including sexual violence, rape and other forms of coerced sex that may negatively affect their health and wellbeing.

Opportunities
• Existence of international declarations and standards on human rights, gender equality, water and sanitation, environment
• Existence of the Tanzania Human Rights Commission (mandated to work in Zanzibar) and its reports
• Existence of several NGOs active in human rights and gender
• Capacity within the Ministry of Labour, Youth, Women and Children Development to address gender issues
• Capacity within the Ministry of State PO for Good Governance and Constitutional Affairs to address human rights issues
• Availability of information on gender inequality.

Policy statements
• Respect of the human rights of each individual obtaining health services from public or private health facilities
• Sensitivity to gender differentials among health staff and programme managers
• High hygienic and environmental standards in all health facilities and other public institutions.
Strategies

- A strategy to promote human rights in the health sector is yet to be developed
- Also, a strategy for gender mainstreaming is yet to be developed
- Reinforce infection prevention and control (IPC) in health facilities, in order to protect the health of health workers and their clients
- Ensure the correct disposal of expired items and medical waste
- Create a mechanism to monitor and improve sanitary conditions in public facilities (for example: an award competition or other innovative approaches).
4. Implementation arrangements

4.1 Community health promotion

Issues
- Community awareness about health and conditions that affect health
- Community involvement in health activities
- Community ownership of health institutions and projects
- Culture, customs and taboos.

Gaps
- Weak capacity and underutilisation of existing staff at the health promotion unit of the MoHSW
- Fragmentation of health promotion activities across different programmes
- Limited community ownership and inadequate local contributions towards health facilities.

Challenges
- Enhancing health promotion activities undertaken by communities themselves
- Harmonise health promotion activities carried out across programmes and projects
- Starting the implementation of the community health strategy
- Overcoming apathy in the community towards actions required to improve local health conditions, due to cultural customs and taboos.

Opportunities
- Adoption of the Community Health Strategy (in 2008)
- Home-based care services are in place (for TB, AIDS and other conditions), in which selected community members serve as providers
- Existence of various types of community health committees
- Availability of health promotion officers (including three in Pemba)
- Training conducted on Participatory, Hygiene and Sanitation Transformation (PHAST) in all districts, involving Shehia leaders and other community members
- Availability of some facilities and materials to undertake IEC activities (such as projectors, loudspeakers, etc.)
- Partner support for IEC activities and health promotion, in particular during epidemic outbreaks
- Additional partner support forthcoming (through HSPS), including technical assistance.

Policy statements
- Work with districts to undertake activities to promote people’s health
- Conducive environment for communities to take charge of the local conditions that affect their own health.
Strategies

- Establish an integrated health promotion forum at the district level, involving all programmes
- Implement the Community Health Strategy (adopted in 2008) with its main components:
  - Address the legal aspects of Shehia Health Custodian Committees (SHCCs)
  - Establish SHCCs
  - Establish a community health information system
  - Peer review system
  - Planning for service delivery demand
  - Supervision
- Enhance the capacity of SHCCs to identify and develop viable community health projects
- Enhance the capacity of districts to oversee and support communities in implementing health activities
- Enhance the capacity of districts to respond to community-formulated demand for services.
4.2 Decentralisation

Issues
- Decentralisation of decision making authority by the central level to lower levels of government and local communities;
- Allocation of resources to those lower levels to enable decision making
- Delegation of certain responsibilities and resources by the centre to semi-autonomous agencies

For:
- Equity
- Greater efficiency
- Greater effectiveness

Gaps
- Very slow progress within government in general to decentralise
- High dependence of districts on central decision making, which (almost by definition) is slow

Challenges
- Gradually shift decision-making authority from the centre to districts and to semi-autonomous institutions
- Support decentralisation with an appropriate legal framework
- Align decentralisation in the health sector (deconcentration) with the general decentralisation process in Zanzibar (devolution, deconcentration, delegation)

Opportunities
- Local Government structures are in place (municipal ..., ward councils, shehia committees )
- Functional District Health Management Teams are in place
- Health Service Fund (HSF) in place to support district health activities
- Proposals made to create a sub-vote for district health in the Government budget
- Possibilities of financial support from external agencies for district health (for example Global Fund for malaria and GAVI for district health systems strengthening)

Policy statements
- Active pursuit of decentralisation in the health sector involving local government authorities.

Strategies
- Pro-actively work together with other ministries to take decentralisation further and develop the appropriate legal and institutional framework; especially with
  - the Ministry of Finance and Economic Affairs and
  - the Ministry of State (PO) Regional Administration and Special Departments
- Capitalise on the HSF experience and channel government funds through this mechanism
4.3 Health sector support services

Issues

- Support services provided by the central level to districts and individual health facilities include the following, amongst others:
  - Integrated supportive supervision
  - In-service training
  - Support for IEC/health promotion
  - Medical and non-medical supplies
  - Maintenance and repairs
  - Technical assistance in planning and budgeting
  - Performance monitoring and evaluation
- Various MoHSW departments and units provide such support services
- Various health programmes and projects under the MoHSW providing support to health institutions in an coordinated manner

Gaps

- Limited capacity of some departments/units at the central level whose role is to provide support services to health facilities
- Insufficient collaboration between national health programmes and projects
- Fragmentation and duplication of certain functions and services, such as IEC, supervision, HMIS, procurement
- Some national health programmes are bypassing the designated central units (CMS, Health Promotion Unit, HMIS Unit, RCH Department)
- Some national programmes and central departments are bypassing DHMTs

Challenges

- (for central level and donor agencies:) Respect the role of DHMTs to coordinate central-level support to district health facilities
- Harmonization of central-level support services for districts
- Promote efficient use of scarce resources

Opportunities

- DHMTs elaborate their own annual Plan of Action (PoA)
- Existing routine of regular review meetings (quarterly at the district level, semi-annually at the zonal level)
- Integrated MoHSW one-year Plan of Action (PoA)
- HSRS and TWGs
- Existence of integrated national healthcare supervision guidelines.

Policy statements

- Sound intra-sectoral collaboration and coordination
- Clear mandates, roles and responsibilities of the various MoHSW departments and units, as well as for the various programmes and projects.
Strategies

- Reinforce DHMTs in their role as district health coordinators
- Continue the existing routine of planning and review meetings, which involve all national programmes
- Strengthen department meetings (Preventive, Curative, Public Health), involving the relevant programmes
- Promote sharing of resources among programmes.
4.4 Intersectoral collaboration

Issues

- Linkages and coordination with other Ministries, Departments and Agencies (MDAs) that oversee other sectors, such as education, agriculture, water, population, etc.
- Joint initiatives with actors from these other sectors to tackle health and health-related problems

Gaps

- No functional forums to oversee intersectoral collaboration in respective areas (only ad hoc meetings when there is a crisis situation)
- No clarity which is the leading ministry for certain intersectoral issues (for instance sanitation, sexual violence)

Challenges

- Several health problems in society require intersectoral interventions as they cannot be resolved by the health sector or the MoHSW alone: especially in the area of sanitation, nutrition and sexual violence

Opportunities

- Existence of the Principal Secretaries’ Committee, involving all ministries (with weekly meetings)
- Existence of intersectoral forums coordinated by the MoHSW:
  - Epidemic control (cholera, etc)
  - Certain national health programmes (EPI, malaria)
- Existence of focal points in other ministries for certain intersectoral issues (for food security in the Ministry of Agriculture, for swine flu in the Ministry of Agriculture, for population in the Ministry of Finance, for HIV/AIDS in the Zanzibar AIDS Commission)
- Designated focal persons in MoHSW for intersectoral issues:
  - In the Public Health Department for the Child Survival, Protection and Development programme (CSPD) coordinated by the Ministry of Finance
  - The Principal Secretary for the Global Fund CCM, coordinated by the Chief Minister’s Office
  - In the Planning Department for MKUZA
  - In the Planning Department for ‘One UN’, coordinated by the Ministry of Finance
  - In the Planning Department for gender, under the Ministry of Labour
- Existence of NGOs that have multi-sectoral programmes
- Participation of other ministries in Partners coordination meetings (PCM) and AJHSR meetings

Policy statements

- Clear mandates, roles and responsibilities of the various MDAs for intersectoral programmes and projects
- Proactive role of the MoHSW to tackle health and health-related problems that require expertise and action from other sectors.
Strategies

• Through the PS Committee, MoHSW taking the lead in establishing functional intersectoral fora (without taking over the responsibilities of other ministries concerned) to undertake joint action for:
  ✓ Sanitation
  ✓ Nutrition
  ✓ Sexual assault, rape and other crimes that have health implications

• During epidemics/outbreaks (such as cholera): taking the lead in establishing appropriate forums and undertaking joint action

• Through the PS committee, MoHSW supporting other ministries in their role to take the lead in establishing intersectoral action in the domain of:
  ✓ Water (for the Ministry of Water to lead)
  ✓ Family life education and school health (for the Ministry of Education to lead)
  ✓ Road safety and prevention of traffic accidents (for the Ministry of Internal Affairs, Police department)

• Ensure exchange of information with other sectors and the general public about intersectoral activities.
4.5 Joint sector-wide planning and review

Issues
- Planning and expenditure reporting system
- Multitude of plans are not aligned to national goals and strategies
- Intrasectoral coordination by MoHSW of all parties

Gaps and challenges
- Multitude of sub-sector strategies and plans, some of which are not aligned with the national strategies (MKUZA, HSRSP) and their goals
- Low capacity in planning
- Multitude of reviews and reporting systems

Opportunities
- Availability of MTEF, POA and formats for strategic planning and reporting
- Ongoing quarterly and semi-annual planning and review meetings
- Annual joint health sector review in place
- Partners coordination meetings (PCM) take place, for donor coordination

Policy statements
- Further pursuit of the sector-wide approach (SWAP) to health sector development
- Effective coordination, integration and rational utilisation of resources made available to the health sector by the government and non-government agencies, including development partners.

Strategies
- Once the present policy will have been adopted, a five-year comprehensive Strategic Plan for the Health Sector will be developed, with a set of milestones (performance targets) and core indicators
- Reinforce the existing routine of comprehensive PoA’s and MTEF, both at the district and the central level
- Simplify reporting procedures by aligning to the five-year Strategic Plan and emphasising performance against set milestones/targets
- Continue annual joint health sector reviews.
4.6 Public-private partnerships

Issues
- Cooperation and coordination between government (through the MoHSW) and private parties
- PPP may involve private for-profit institutions (such as private hospitals), as well as not-for-profit institutions and organisations (such as faith-based organisation, NGOs)
- PPP may involve providers of health services, as well as providers of support services (such as security services, cleaning, laundry, repairs, transport)

Gaps and challenges
- Participation of private parties in service provision (for example the response of private hospitals to epidemic outbreaks & emergencies) is not yet being overseen in a systematic manner by the MoHSW
- Not all private facilities submit health information to the DHIS/HMIS
- Very little experience in the public sector in sub-contracting private providers

Opportunities
- Several private hospitals/clinics and health organisations are interested in working together with the MoHSW
- Several partnerships (PPP) are ongoing (for instance Rahaleo, ZOP, Makunduchi hospital, malaria, RCH, e-learning initiative under the Continuing Education Unit in MoHSW) from which lessons can be learned
- Some NGOs are taking part in AJHSR, health partners’ coordination meetings, TWGs and other forums
- A focal person for PPP is in place in the MoHSW

Policy statement
- Enhanced private sector involvement in realising the GoZ health policy in terms of:
  - the provision of ‘health services with a public purpose’ by private parties
  - the provision of health sector support services by private parties
  - private funding (or co-funding) of such services.

Strategies
- Explore and promote the involvement of NGOs and private firms in the delivery of health services and sector support services
- Engage in formal partnerships with private parties, where appropriate, by concluding written agreements (contracts, memoranda of understanding) to that effect, which carefully stipulate the expectations and commitments from either side
- Explore the possibilities for contracting out certain services and implement, if found appropriate.
- Monitor each individual PPP contract and memorandum of understanding, with the explicit aim to draw lessons how these partnerships can help achieve health sector targets even better.
References


Other national sector policies:
- Zanzibar Education Policy, 2006
- Zanzibar Population Policy, 2008
- Zanzibar Public Service Policy, draft version.

Other references: